



May 1985

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### Recommended Citation

McCoin, John M. (1985) "Evolution of Adult Foster Care," *The Journal of Sociology & Social Welfare*: Vol. 12 : Iss. 2 , Article 11.

Available at: <https://scholarworks.wmich.edu/jssw/vol12/iss2/11>

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## EVOLUTION OF ADULT FOSTER CARE

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### ABSTRACT

Adult Foster Care evolved under the influence of the Catholic Church and dates to about 600 A.D. Gradually, it has been brought under the influence of the State. In 1979-80, the author surveyed 49 states and determined that 34 states had formal regulation. currently, Adult Foster Care is cost effective and reasonably humane. The future appears to have considerable promise and the need for AFC is proliferating.

The purpose of this article is to trace the development of Adult Foster Care from its inception to the present, the numerous relevant variables which have impacted upon its evolution, discuss relevant theoretical concepts, and to make some recommendations for future research. It is hoped that this article will assist in the development of an enhanced appreciation and comprehension of an ancient stepchild of the Social Work profession and larger society.

Although a considerable amount has been written about what can be considered Adult Foster Care (hereafter referred to as AFC), readers must infer this from the plethora of terms extant in the literature. As denoted by McCoin (1983), some of these terms are: 1) Boarding Homes, 2) Board and Care Homes, 3) Community Care Homes, 4) Residential Care Homes, 5) Personal Care Homes, 6) Adult Family Care Homes, 7) Adult Boarding Facilities, and 8) Shelter Care Facilities. McCoin (1983) presented an argument for unifying the termin-

ology by simply terming these homes (if licensed or certified by the respective state) Adult foster Homes. The people operating these homes were categorized as Managers and the people living in them were categorized as Residents. Managers operate and often own the homes and the residents are usually formerly institutionalized people with histories of mental illness, mental retardation, and the dependent elderly.

### Origin and Development

The beginning of AFC has been placed at 600-700 A.D., in Gheel, Belgium (Kilgour, 1936; Dumont & Aldrich, 1962). The legend goes that at the time the beautiful Irish Princess Dymphna was slain by her mentally deranged father, the pagan King of Ireland, over her refusal to marry him. Heartbroken over the death of Dymphna's beautiful Catholic mother and as his subjects could find no other woman in Ireland resembling Dymphna's mother, the King wanted only Dymphna as a replacement. Horrified by her father's proposal, Dymphna sought solace from her priest, Father Gerebernus, who advised that they flee for their lives (Aring, 1974). Angered, the King led his entourage, overtaking them at Gheel, Belgium where the King ordered both slain. His subjects slew the priest but refused to harm the beautiful Dymphna whereupon the King decapitated her (Goldenson, 1970; Aring, 1974).

Continuing, the legend indicates that the Gheel citizens were so horrified by this insane act that they constructed an annex to a local church on the actual site of Dymphna's remains; these were gradually believed to possess a spiritual quality for curing the mentally ill. Aring (1974) reports that so many people believed that they were cured by

Dymphna's spirit that she was Canonized a Saint in 1247 A.D. The exact time that the pilgrimage of mentally ill pilgrims Began to overload the local hotels is undetermined. At any rate, townspeople began taking them into their own homes while the pilgrims underwent treatment by church officials to help exorcise the evil spirits of insanity. To assist in this process, the pilgrims worshipped the spirit of St. Dymphna. Aring (1974) reported having been positively impressed by the spontaneity of the Gheel townspeople, even children, toward the mentally disabled.

Control over colony Gheel continued to be exercised by the Catholic Church until about the turn of the 19th century when Napoleon's antichurch policy resulted in municipal control. In approximately 1852, the State assumed control but delegated operational control to the medical profession (Kilgour, 1936). This control has continued into modern times (Dumont & Aldrich, 1962; Srole, 1977).

Colony Gheel thus became the prototype for AFC programs, which were to develop in several countries in the 19th Century. Scotland had a program in operation by 1967 (Pollock, 1945) with Massachusetts beginning its program in 1882 (McCain, 1983) and France in 1892 (Aptekar, 1965). Aptekar also indicates that Switzerland had a program by 1909, Germany by 1911, and the Province of Ontario, Canada by 1933.

Probably due largely to the courageous and dynamic leadership of Dorothea Dix, more humane forms of treatment for the mentally disabled were evolving by the middle of the 19th Century. Moreover, it was also at about this time that the medical profession began assuming more responsibility or treating the mentally disabled

For these and possible other reasons,

various leaders from the U.S. inspected the AFC programs in Scotland and Gheel. As a consequence, Massachusetts became the patients were placed in homes in 1882 (McCoin, 1983). In the early 20th Century Rhode Island and Maryland's Springfield State Hospital experimented with AFC (de Alvarado, 1955). However these programs were short-lived.

In the throes of the Great Depression, New York became the second state to officially adopt a policy of AFC in 1935, followed in quick succession by several other states (Morrissey, 1967). This period marked the beginning of AFC in its present form, including the widespread entrance of the Social Work profession as the primary discipline responsible for its implementation (McCoin, 1983).

By late 1979, thirty-four states were determined to have officially-sanctioned AFC programs principally serving the mentally ill, mentally retarded, and dependent elderly (McCoin, 1983). From the 1940's to 1960's. most of the literature on AFC was by psychiatrists in the American Journal of Psychiatry (McCoin, 1983). The Veterans Administration (hereafter referred to as the V.A.) officially adopted a policy for AFC in 1951 (U.S. Veterans Administration, 1971).

In slightly over a decade from the 1960's to 1970's, the V.A.'s contribution to AFC tripled so that by 1979, the V.A. had between 12,000-15,000 individuals placed in Foster Care (McCoin, 1983; Engquist, 1979). During that period there was a similar growth among non-veteran AFC populations. Also, the 1960's-70's, witnessed a proliferation of journal articles and doctoral dissertations by social workers (e.g., Smitson, 1967, Evans, 1976, Kaufman, 1976).

## Conceptual Consideration

Essentially, the basic concept for AFC appears to have been the family, more specifically, the extended family. However, as Coleman and Cressey (1980) indicate increasing industrialization has been a causal factor in the decline of the extended family. It is hypothesized moreover that vestiges of the extended family still survive in AFC, albeit they are less natural and more or less institutionalized through the Welfare State. Nevertheless, AFC still resembles the extended family in many respects, e.g., by providing nurturance, sustenance, and care to non-relatives, but for financial remuneration to managers of AFC homes (McCoin, 1983). With the decline of the extended family, which previously largely cared for its ill and dependent members, AFC partially fills a void which can presently be filled only via the instruments of the Welfare State. Perhaps as a compromise between the naturalism of the extended family and the pragmatism of the Welfare State, the principle of normalization, developed in the Scandinavian countries (Willer & Intagliata, 1982), has come to represent more rights and privileges for handicapped people in the least restrictive environment (Miller, 1977). Normalization and least restrictive environment are two fundamental guiding principles in deinstitutionalization.

In our materialistic society, young and healthy people are almost revered while the disabled and dependent elderly are often the victims of "human obsolescence" (Henry, 1963 p. 406), or they are socially marginal. Segal, Baumohl, and Johnson (1977) coined the term "social margin" (p. 406) which seems relevant for AFC residents. Socially marginal people are essentially in poor health, have limited financial and social resources, and they are considered obsolete in our fast-paced society. As a consequence, there is a break-

down between the socially marginal person and the social environment, termed the "Social Breakdown Syndrome" (McCreath, 1984, p. 438). This syndrome even applies to relatively young, often well educated adults, not to mention the elderly and mentally retarded. As a consequence, professional human service workers need to serve more as advocates for them (Cournow, Herman & Glick, 1984) and to ameliorate the tendency to blame the client for events leading up to his/her dilemma (Kagle & Cowger, 1984).

Morrissey (1967) coined the term "emotional allergy" (p. 42) to help explain the often acrimonious relationships existing between mentally ill people and their families. This essentially means that relations are so strained that continued living together is therapeutically contraindicated, thus leaving few options save for prolonged institutionalization, AFC home placement, or joining the ranks of the estimated 110,000 homeless people in the U.S. on any given night (Public Administration Times, 1984). Finally, it seems reasonable to extrapolate the emotional allergy concept to the mentally retarded and dependent elderly and their families (e.g., Hill, Rotegard, & Gruininks 1984; Giordano & Giordano, 1984).

Attempting to deal with the many theoretical concepts possibly relevant to AFC is beyond the scope of this paper. Nevertheless, the following are attempts to address what are considered to be particularly important concepts for residents. One concept would appear to be relevant for all categories of residents would be that of alienation. Through the Dean Alienation Scale, this concept was operationalized on a sample of male schizophrenic AFC residents and psychiatric inpatients. Through Chi Square Statistical analysis, McCoin (1977) found that residents who had been in AFC homes for long periods (up to 15 years) scored lower

on alienation, ( $P = .045$ ) than residents who had been in AFC homes only 6 months. Findings from the same study indicated that residents who had been in AFC homes up to 15 years scored lower on social isolation than a contrast group of psychiatric inpatients ( $P = .015$ ). These findings present some interesting challenges for future researchers, especially with the mentally retarded and dependent elderly.

Other empirical research has demonstrated significant symptom reduction in mental patients who were in AFC homes in Canada for up to 18 months (Murphy, Englesman, & Tchong-Laroche, 1976). Moreover, they reported almost no improvement in social functioning. A more carefully controlled study, however, did demonstrate a significant improvement in social functioning of former psychiatric patients who had been in AFC homes for 4 months (Linn, Klett, & Caffey, 1982). Another study (Srole, 1977) also demonstrated positive social functioning and attitudinal changes in the majority of residents studied. Willer & Intagliata (1982) report functioning and attitudinal changes in the majority of residents studied. Willer & Intagliata (1982) report that mentally retarded residents are more likely to improve behaviorally in AFC homes than in group homes. Linn and Caffey (1977) suggest AFC homes for some geriatric patients in lieu of premature nursing home placements. They also indicate that elderly psychiatric patients are more likely to be diagnosed as having organic brain disease, as opposed to schizophrenia.

Ellenberger (1960) indicated that wild animals in captivity sometimes become so attached to their cages that they will not leave even if afforded the opportunity. By extrapolation, it seems feasible that a similar dynamic may be operative within some patients before and after they become AFC residents.



That is, the person may want to nestle in the institution of AFC home, perhaps somewhat analogous to a young bird's reluctance to leave the nest. In clinical circles this would be more likely to be considered institutionalization, i.e., the tendency of clients to nestle in either the hospital or AFC homes and to be fearful of leaving. One rationale is therefore to transfer these nestling needs from the hospital to AFC home where the residents could possibly have Authoritarian-type managers to guide, direct and protect them, not drastically different from institutional living. By way of contrast, some authors contend that nursing homes and AFC homes with over 10 residents should be categorized as institutions (Linn, Klett, & Caffey, 1980) while McCain (1983) considered homes containing up to 20 residents as AFC homes, provided that they were formally regulated. Regardless of which concepts are utilized, AFC managers must strike a delicate balance in managing some residents, e.g., those schizophrenics who regress if ignored too much and become hyperactive if subjected to much stimulation. Some research has shown that manager-initiated activities for non-schizophrenic residents is therapeutic but is related to deterioration in schizophrenics (Linn, Klett, & Caffey, 1980).

Let us now focus our attention on some possible reasons why managers elect to take strangers into their homes. First, one must consider the financial aspect, or simply the profit motive. Yet, this does not adequately explain the phenomenon as the monumental responsibilities involved could tend to attenuate this motive, not to mention the less than adequate financial remuneration received by managers. As an interesting aside, AFC managers in Gheel, Belgium in 1936 received only about 15-25 cents per day for each resident (Aring, 1974).

Empirical research has demonstrated that

most managers are past the childbearing age (Steffy, 1976; Zweben, 1977; Intagliata, Crosby & Neider, 1981). Deykin, Jacobson, Klerman, & Solomon (1966) utilize the "empty nest syndrom" (p. 1422) to attribute causality for depression in some middle-aged women. Since many AFC managers are Female and middle-aged (or older), and past the childbearing state, they may be partially motivated to keep residents in order to replenish the empty nest, so to speak. Stated somewhat differently, perhaps they take strangers into their homes for a combination of reasons including the need to mitigate against depression and loneliness. Furthermore, middle-aged and older male managers may also be susceptible to the same syndrome. Finally, as delineated earlier in this section, AFC residents may tend to complement the managers' nesting needs by nestling in them, or becoming attached to them, not drastically different from institutionalization.

Besides the nesting syndrome another possible factor to help explain why managers take residents into their homes could be the "rescue fantasy" (McCoin 1983, p. 197-198), i.e., the need to rescue people in trouble. Vander Zanden (1984) utilized the term "prosocial behavior" (p. 273) which can help explain why some people are more rescue-focused than others. The same publication assesses empirical research on "Good Samaritans" in California (p. 279), indicating that many of the rescuers of people in trouble seemed indifferent or angry toward those they rescued. Apparently the rescuers thought the victims brought on the misfortune by their own deeds, thus possibly indicating a high degree of authoritarianism present in the rescuers' personalities. Moreover, the California rescuers sometimes would leave a dying victim to pursue the perpetrator and seemed jealous of others who tried to intervene on behalf of the victim. The question then arises as to whether the

rescuers did not obtain a psychological high from these experiences, possibly motivated by aggressive instincts related to power, control, competition, and possible sex.

The degree of authoritarianism in a sample of AFC managers from a large program was measured by the California F Scale (McCoin, 1977, 1979, 1983). Essentially, people with authoritarian personalities tend to be highly opinionated, moralistic, politically conservative, rigid, unable to tolerate ambiguous situations, readily accept orders from higher authority, and tend to be punitive toward subordinates. McCoin (1977) hypothesized that managers, scoring high on authoritarianism, would have residents scoring higher on alienation than residents living in less authoritarian homes. This hypotheses, however, was not confirmed. One possible inference from this conclusion is that a degree of authoritarianism in managers may be necessary to help them tolerate some awesome responsibilities. Also this authoritarianism may offer a measure of security to insecure residents. At least, they may feel the managers care, albeit perhaps not in the most therapeutically ideal manner. Ideally, it seems feasible to recruit and retain more egalitarian managers. At this stage in the evolution of AFC, the law of supply and demand does not smile on such a proposal.

For humane reasons, it would seem desirable to have more egalitarian managers. McCoin (1977) found a statistically significant association by Chi Square analysis ( $P = .0074$ ) on education and authoritarianism in a sample of AFC managers, i.e., the less educated ones were more authoritarian. Furthermore, the same research demonstrated an association between manager-authoritarianism and ethnicity ( $P = .0675$ ). Italian managers were more authoritarian than descendants of the British Isles or Blacks. One plausible explanation for this

finding is that many of the Italian managers were from the old country and less educated. A statistically significant association ( $P=.0046$ ) was found in the same study between manager-authoritarianism and religion, i.e., managers in the "Other" category of religious preference scored lower on authoritarianism. More specifically, a large percentage of these were Jewish. Catholics scored slightly higher on authoritarianism than Protestants. Needless to say, more research is needed on managers and authoritarianism.

### Current Programs

In 1979-80, the author conducted two nationwide surveys involving State Administrators of Mental Health, Mental Retardation and Aging, covering all states except Missouri, which did not respond. The purpose was to better describe AFC from an administrative perspective (McCain, 1983).

The responses from these surveys seemed to be more positive than negative, indicating that AFC is a reasonably viable and humane alternative to prolonged institutionalization. Some of the advantages mentioned in these surveys were helping residents to re-establish feelings of self worth and dignity, helping to re-establish family network ties, delaying premature nursing home placements, helping to re-integrate residents into society, and cost effectiveness.

The preceeding are some potent reasons favoring AFC. For legislators, policy makers, and administrators, cost effectiveness no doubt ranks high, especially in this era of budgetary constraints on social and human service programs. In most states a resident can remain in AFC for \$15-20 daily. In contrast, nursing home placements usually cost about three times as much and hospitalization can cost 8-12 times as much as AFC, or more.

Viewed within the purview of cost effectiveness, AFC can be viewed as one of the few bargains in the health care industry.

A serious problem besetting AFC today is that approximately 11 federal agencies impact upon it (McCrary & Keiden, 1978). This does not count numerous state, local, and private agencies. Local zoning ordinances often restrict developing programs (Gupaiuolo, 1979), with higher status neighborhoods being more resistive. Some state administrators were critical of the lack of uniform national policy on AFC. Others were critical of the dearth of structured activities in the homes and communities. A minority of the administrators referred to the potential for resident abuse by managers, albeit none actually cited any specific instances of such abuse. Nevertheless, some authors have criticized the sometimes widespread policy of dumping the mentally disabled into communities with minimal supervision and resources (Titmuss, 1968; Anderson, 1978). Furthermore, it appears that the states most responsible for this practice are those with the least amount of statutory control.

In most instances, the cost of the resident's care is borne by the resident through Social Security disability or retirement income, Supplemental Security Income (referred to hereafter as SSI), V.A. disability benefits, or a combination of these and sometimes other resources. In Michigan, General Assistance and Medicaid also help defray expenses in some instances. Additionally, Michigan has mandated amount which managers receive monthly for keeping residents. For example, in 1979, a manager there received \$210 if the resident were an SSI recipient. Presently, managers in Michigan receive about \$470 monthly per resident, but some there sometimes accept a resident at the General Assistance rate which is less than the prescribed amount. If the resi-

dent is a G.A. recipient in Michigan, he/she received \$28 monthly spending money as of 1983. In the same year a resident in Michigan on SSI received about \$30 monthly and \$50 if receiving Social Security benefits. In contrast, empirical observations indicate that Missouri does not mandate a specific amount of spending money for residents. This practice may be fairly prevalent in the U.S., thus posing serious ethical and policy questions. Since a considerable number of residents' income is means tested in the U.S., earning extra income for them is financially contraindicated, far different from the observations of Aring (1974) to the effect that AFC residents in Gheel, Belgium in 1936 were encouraged to obtain competitive employment and their earnings were not means tested.

By 1979, thirty-four states were determined to have some type of statutory control over AFC homes (McCoin, 1983). Kansas and Missouri currently have statutory control of AFC, thus making at least 36 states which have some form of state regulation.

In the United States, AFC is a mish mash of programs. The lack of uniformity from one region to another poses many problems of administrators and clinicians, not to mention residents and managers. One author depicts AFC as so unique in the mental health field that he terms it a "mongrel" (Zweben, 1977, p. 148). As Zweben further indicates, other mental health programs usually have a more uniform approach to patient care. McCoin (1983) refers to AFC as "adopted child" (p. 103), "bastard child" (p. 40), "unwanted step-child" (p. 168), with all of these terms referring primarily to the Social wards which have been merely moved into various communities (Lamb & Goertzel, 1971). In a more positive reference, Schrader & Elms (1972) depict AFC as the "Cinderella" of the mental health field as its potential has been so

neglected (p. 9).

The preceeding is a brief description of AFC in the U.S. today. Comparative analyses of these programs with those of other countries would be interesting especially with Canada and England. In England, the term "Adult Fostering" (Ware, 1983) is being utilized to describe what is analogous to AFC in the United States. In England and the U.S., Departments of Social Service (or their equivalents) are assuming more responsibility for licensing, although in the U.S. numerous states still license some AFC homes under the Department of Mental Health, Department of Health, or similar departments. Currently the practice of implementing AFC comes almost exclusively from the Social Work profession.

### Conclusions

AFC is a 1300 year old unwanted stepchild of the Social Work profession. Despite its long history, AFC has generated relatively little interest among Social Work researchers and administrators from the National Association of Social Workers. Bogen (1984) appears to believe that this lack of concern about AFC will likely change relatively soon. Regardless of the lack of concern by academe and NASW, Adult Foster Care has become a noteworthy service to partially fill the vacuum created by the decline of the extended family, especially for the mentally ill, mentally retarded, and dependent elderly. The evolution of AFC has been affected by the Catholic Church, Napoleonic Wars, Great Depression, and countless other factors including the policies of the "New Frontier" and "Great Society". Futhermore, there appears to be some correspondence between the proliferation of AFC homes and Social Work's largely breaking the Freudian tradition in the 1960's. Since then, Social Work has concentrated less on the individual and more on the interaction

between people and the environment, a philosophy more conducive to the development of Adult Foster Care. Before the 1960's most journal articles on AFC were by psychiatrists whereas most of them since have been by social workers.

Theory development is still at a very low level and few attempts have been made to operationalize the numerous relevant theories extant in Sociology, Psychology, Psychiatry, Economics, and Business Administration.

Much remains to be accomplished at the level of clinical practice. For example what theoretical approaches can best be utilized with what types of residents and managers? Some Agencies still treat AFC as the unwanted stepchild, e.g., assigning higher status to other programs. A uniform national policy on community-based shelter care for the mentally ill, mentally retarded and dependent elderly is sorely needed. Sometimes residents and managers fall through the cracks between bureaucracies. Many times there is duplication and overlapping of effort. Politicians, policy makers, and administrators should be held more accountable, not just service providers and clinicians. Too frequently, states cannot or will not supplement Supplemental Security Income resulting in an uneven distribution of financial resources. Some residents are penalized by means tested incomes. Furthermore, some states are financially penalized over transferring residents from nursing homes to AFC homes. More dynamic leadership is needed for a 1300 year old unwanted stepchild to be allowed to grow to maturity.



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